

and if the cause can be found the patient may be warned to avoid it after the operation has been performed, in order that permanency may be rendered more probable.

5. That in the case of chronic hernia the cause is never one acting suddenly and singly, as overlifting, strains, falls, etc., but always one acting slowly, persistently, gently, habitually (such causes are difficulties in urination and defecation, certain occupations, and, chiefly and most prominently, coughing in all its forms).

6. That the claims of any operation for the radical cure of chronic hernia cannot at present be properly estimated, and that they never can be unless acute and chronic herniæ are absolutely separated, and the true effective causes of them are duly appreciated, other causes being previously carefully eliminated.

ENTERECTOMY BY PAUL'S METHOD.

PAUL reports the following (*British Medical Journal*, 1894, No. 1727): Woman, aged fifty-one years, was admitted to the hospital, having a strangulated femoral hernia with the usual symptoms. After exposing the intestine, an area was found which had already begun to slough, and from which the contents made their appearance. An incision was therefore made in the median line of the abdomen, and after carefully cleansing the hernia it was drawn into the abdominal cavity, care being taken to prevent contact with the peritoneum in the proceeding. After clamping above and below, the injured portion was cut out with scissors, together with the corresponding mesentery, bleeding-points were ligated, and the divided ends united by a bone tube as recommended by the author. The proximal extremity was dilated, and the distal end contracted, so that it was found impossible to invaginate the former into the latter as the author had heretofore done. It was, therefore, necessary to employ a tube of small size ($\frac{5}{8}$ in. $\times$ $1\frac{1}{4}$ in.), fastening this in the distal portion, and by means of the traction thread this was then invaginated into the proximal end—in a direction, therefore, against the current of the contents, and although this method had been found to give good results in the case of experiments on dogs, the author hesitated somewhat about employing it in practice. The patient made a good recovery. During the first twenty-four hours the patient was allowed the yolk of an egg, two ounces of brandy, and some beef essence. This was gradually increased as the condition of the patient warranted.

HORRICKS details in the same journal the following case: A woman, aged thirty-eight, was admitted to the hospital with intestinal obstruction and with severe abdominal pain. Above Poupart's ligament, on the right side, a solid tumor was felt. An exploratory incision was made, which disclosed a tumor implicating a considerable portion of the small intestine. The wound was closed, and the patient recovered from the operation without complication. Three weeks later an operation was performed for the relief of the obstruction. A 3-inch incision was made in the median line rather above the middle. The tumor was drawn out of the incision, and, after emptying and securing the bowel on either side, a V-shaped section of mesentery containing enlarged glands and the affected bowel was excised. After securing the bleeding

vessels a Paul's bone tube was introduced into the lumen having the smaller diameter, and after securing with continuous silk suture it was invaginated into the other open extremity in the manner advised by Paul. The portion of intestine removed measured 39 inches in length; the tumor was found to be a large round-celled sarcoma. The patient made an uncomplicated recovery, and was discharged well at the end of five weeks.

THE DIAGNOSIS AND OPERATIVE TREATMENT OF SOLITARY HYDATID CYSTS OF THE SPLEEN.

AFTER a careful discussion and report of a case operated on by himself, and a study with a summary of sixty-six cases, TRINKLER (*Revue de Chir.*, February, 1894) comes to the following conclusions:

The facts cited speak clearly in favor of operative intervention in the treatment of hydatid cysts of the spleen. This intervention should have for its purpose the discovery of the cyst. Laparotomy, in the full acceptance of that term, should be employed—that is to say, with all the variations proposed by Messrs. Volkmann, Lindemann, Laudau, Sängers, etc., accommodating itself to the peculiarities of each cyst.

It is difficult to judge in theory of the merits or demerits of operative procedures, for they all have their good points. There are cases in which Volkmann's operation is apparently less dangerous; nevertheless, when the tumor is small with thick walls and few adhesions, one can, without risking much, operate after the method of Lindemann, Sängers, or Pozzi. The last method is the ideal, as the cyst is removed entire.

As a general rule, the incision should be as long as possible; it never does any harm, especially if one desires to employ Volkmann's method.

Possibly one might have to put a couple of stitches more at the top and bottom of the incision at the end of the operation, but it will give the chance to explore all parts of the tumor, to determine its boundaries, its pedicle, and, in short, one will see the actual condition of the organ, a most important factor in planning the operation. As Koenig says, before all one must "see," and this is only possible by a free incision. Consequently the first incision is exploratory and on it depends the choice of operation.

THE ANTISEPTIC POWER OF ICHTHYOL.

FROM interesting bacteriological researches which he has carried on in the hygienic institute of the University of Greifswald, ABEL (*Centralbl. für Bakt. und Parasit.*, 1893, Band xiv., No. 13) deduces the following conclusions concerning its antiseptic and bactericidal power:

1. The ichthyol preparations—ammonium ichthyol and sodium ichthyol—are capable of killing, in weak solutions and short time, the streptococcus pyogenes and erysipelas. The working of the different preparations is just about the same. In suppuration arising from these bacteriological sources, ichthyol can be used with good results, as has been already shown by actual experience.

2. The staphylococcus aureus and albus, the bacillus pyocyaneus, bacilli of typhoid, ozaena, and anthrax, the spirillum cholerae Asiaticæ, possess a

greater or less resistance to ichthyol, that in certain cases is so marked that pure ichthyol must remain on them for hours before the organisms in the cultures are killed. This is not, therefore, the most useful antiseptic for these organisms.

3. Diphtheritic bacilli, in fresh colonies, were killed by weak solutions of ichthyol, while further developed colonies were overcome with greater difficulty. Therefore, although ichthyol is not useful in the therapeutics of diphtheria, it can be used in prophylaxis both as gargles and in internal medication.

4. Ichthyol has done good service in the treatment of typhoid and ozena by making the irritation less harmful. It is, therefore, not impossible that also the other infectious diseases mentioned in paragraph 2 may be favorably influenced by ichthyol, whereby, although we can expect little from its antiseptic power, its chief influence may be hoped for in its action on the system.

5. It is recommended that ichthyol be employed only in substance or in a fifty per cent. solution, and where greater dilution is used only with greatest precautions. Weak solutions may contain pathogenic spores, as, for example, staphylococcus aureus, even for a long time, and one must run the risk of reproducing the disease by its use. Weak solutions that have been used before must be sterilized before they are used again, by heating, which can be done without injury to the antiseptic power.

A CASE OF ANTHRAX.

BURRELL (*Annals of Surgery*, December, 1893) reports a case of anthrax, with clinical history and the results of bacteriological examination. The patient made a complete recovery after thorough excision of the growth. The author makes the following deductions from this case:

1. That where applicable the old and obvious method of treatment by complete excision of the pustule, when vital structures are not involved, is best.

2. That where extensive surfaces involving vital parts are involved, the treatment by injecting strong solutions of the most energetic antiseptics may be used.

3. That glandular swelling about the malignant pustule, and apparent systemic poisoning do not contra-indicate operative treatment.

THE RADICAL CURE OF LARGE UMBILICAL HERNIÆ.

GEBSUNY (*Centr. f. Chir.*, 1893, No. 43), after discussing the methods employed for closing wounds of the abdomen after laparotomies, recommends the following method for the prevention of relapse after radical operation for umbilical hernia. The method is similar to that employed by him in all his laparotomies. After the incision of the hernial sac, the umbilical scar tissue, which he finds usually adherent to the hernial sac, is resected, and the sac is separated by blunt dissection from the surrounding adipose tissue and then divided. The mesentery is then ligated, if present in the sac, and divided, the stump, together with any intestine, being returned into the abdominal cavity. The sac is then drawn out as far as possible and sutured at the level of the hernial ring; the suturing of the ring then follows.

The peculiarity of this operation lies in the following steps: The recti muscles are next found, most easily by extending the median incision upward in the line of the linea alba. The fibrous sheaths of the recti are divided in their median edges until a point is reached above and below the level of the umbilicus. The distance of the recti muscles from the umbilicus makes it necessary to dissect them out of their sheaths, and especially the tendinous lineæ transversæ, before they can be made to meet in the middle line. They are then united in the middle line by a running suture. The skin is then sutured after the removal of some of the adipose tissue or at least its free dissection up from the underlying fascia. The author believes that by this method he affords a strong support to that part of the abdominal wall about the umbilicus which is liable to be weakened by the spreading apart of the recti muscles.

DERMATOLOGY.

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PEMPHIGUS.

J. F. PAYNE, the well-known dermatologist of St. Thomas' Hospital (*Lancet*, 1893), considers the disease in its several aspects, and recognizes the following forms as being more or less accurately denoted by this name. 1. Pemphigus vulgaris, of which there is an acute febrile form and also a chronic or recurrent form. 2. Pemphigus foliaceus, an extremely rare disease. 3. Pemphigus vegetans, one perhaps still rarer. More doubtfully deserving of the name are: 4. Congenital traumatic pemphigus, a state of the skin that is mostly congenital, sometimes being called "epidermolysis hereditaria bullosa." 5. The so called pemphigus neonatorum. There is also a bullous syphilide that is sometimes called pemphigus syphiliticus. In addition to these we meet with forms of disease resembling pemphigus, which were formerly included under that name, but are now called by such names as erythema bullosum, dermatitis herpetiformis, hydroa, herpes gestationis, etc. The only character common to all forms of pemphigus is that the eruption consists of blebs. The question of the existence of febrile pemphigus, denied by some writers, is discussed, with the report of five cases, which show that acute outbreaks of pemphigus associated with fever, which mostly occur as episodes in the chronic form of the disease, are occasionally met with. Concerning the treatment, the writer is in accord with Hutchinson's estimate as to the value of arsenic, but thinks that there are certain